

SUMMARY OF NATIONAL PROPOSALS TO CHANGE THE MEDICAID PROGRAM

A Report Prepared for the

Legislative Finance Committee

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SUMMARY

The President, a Medicaid Commission established by the Secretary of the U.S. Department of Health and Human Services, and the National Governors' Association (NGA) have all made proposals on how to achieve Medicaid spending reductions and stability – both for the federal and state governments. This memo:

- Provides summary statements of the major proposals for short-term savings made by each entity
- Lists national and Montana costs when estimates are available
- Includes an attachment discussing Montana specific cost estimates for one of the president's budget proposals
- Includes an attachment summarizing short run Medicaid recommendations made by the NGA

As part of his 2006 budget proposal, President Bush recommended \$10 billion in Medicaid spending reductions. Congress has not taken action on the President's recommendations, but is reviewing the Medicaid program with the goal to issue cost saving packages of \$10 to \$14.7 billion to take effect in 2007.

Most of the commission recommendations are also included in the NGA recommendations. Some of the NGA recommendations may be considered in congressional legislation.

There is little Montana specific information available for each specific proposal. The impacts from some of the original federal executive budget proposals are discussed in attachment to this memo. However, Congress seems more inclined to adopt other cost saving measures and at this point, most of the other recommendations do not appear to adversely affect Montana Medicaid costs. While there would be workload impacts and also impacts to Medicaid beneficiaries, those costs and specific impacts have not been identified.

The Medicaid Commission and the NGA will also propose and publish recommendations on long-term changes to the Medicaid program. If the Legislative Finance Committee desires, additional information can be provided at its next regularly scheduled meeting.

ADMINISTRATION PROPOSAL

President Bush's budget proposal includes several major and fundamental changes to the Medicaid program that could significantly alter funding for nursing home and community services for the elderly and disabled, and would cap administrative cost sharing¹. The anticipated savings of these proposals is estimated to be about \$10 billion. The most important proposals would be to:

- Lower the federal match rate for case management services from the benefit match rate (about 70 percent in Montana) to the administrative cost match of 50 percent
- Clarify which services may be claimed under case management, significantly narrowing the number and type of services that could be Medicaid eligible

¹The federal share of Medicaid benefit costs varies among states and is based on changes in a state's per capita income over three years compared to the change in national per capita income. The Montana Medicaid benefit match rate is about 70 percent and like administrative costs, the federal government pays all allowable costs without ceiling or limit. The vast majority of Medicaid administrative costs are matched 50 percent by the federal government (in all states) and the federal government pays its share of all allowable Medicaid administrative costs, without a cap or ceiling.

- Narrow the definition of rehabilitation services that would be eligible for federal reimbursement²
- Lower the ceiling on provider taxes from 6 to 3 percent of gross receipts for the class of providers subject to taxation
- Change the upper payment limit for Medicaid reimbursement to no more than the cost of services and potentially eliminate intergovernmental transfers³ (IGT)
- Limit administrative costs to a capped amount with a fixed inflationary adjustment amount

MONTANA IMPACT

The Department of Public Health and Human Services (DPHHS) estimated in July 2005 that the general fund cost of the case management match rate proposal would be \$5 million general fund this fiscal year. Elimination of IGTs would reduce nursing home reimbursement by an estimated \$20 million total funds compared to a total FY 2006 appropriation of \$134 million. During the 2005 legislative session, DPHHS calculated the hospital tax in relationship to the 6 percent ceiling and found that the tax was well within guidelines. At the end of FY 2005, DPHHS calculated that the nursing home bed tax was 4 percent of gross receipts and would be right at 6 percent at the end of FY 2007.⁴ Reducing the nursing home bed tax fee to no more than 3 percent would reduce it by half and presumably lower reimbursement rates by about 5 percent (not including the patient contribution). There is no information on the impact of changing the upper payment limit.

MEDICAID COMMISSION

The Medicaid Commission issued its recommendations for short-term savings in the Medicaid program September 1, 2005. Most of these recommendations were also made by the NGA. Each proposal and the estimated cost savings nationally are:

- Change drug reimbursement from average wholesale price to average manufacturer's price⁵ (\$4.3 billion over five years)
- Extend drug rebates to Medicaid managed care contracts (\$2 billion over five years)

² While the Centers for Medicare and Medicaid Services (CMS) has not further defined case management services in regulations, activities commonly understood to be allowable include: (1) assessment of the eligible individual to determine service needs, (2) development of a specific care plan, (3) referral and related activities to help the individual obtain needed services, and (4) monitoring and follow-up. Provision of therapeutic services is not allowable as a case management service. These services and federal reimbursement for them have come under increasing scrutiny for several years. It is the interpretation of staff from the National Conference of State Legislatures (NCSL) that the scope of services allowed as case management will be significantly narrowed – Joy Johnson Wilson, Health Policy Director, NCSL, Chicago, Illinois, September 6, 2005, comments at the Fiscal Analysts Seminar during the general session on Federal Budget and Medicaid Updates

³An intergovernmental payment is funding from state or local governments that is used as state Medicaid match to draw down federal matching funds, which are then repaid to public, non-state Medicaid providers. IGTs have been used to increase Medicaid nursing home rates and some mental health Medicaid rates. Sometimes states, counties, and local governments have retained a share of the IGT and diverted the funds to uses unrelated to providing services for which the payment was made.

⁴Norm Rostocki, Chief Centralized Services Bureau, Senior and Long Term Care Division, DPHHS, personal communication, September 22, 2005.

⁵The average wholesale price (the price a producer is willing to sell its produce and a buyer is willing to buy the produce) varies widely and is believed to be inflated. The average manufacturer's price would ostensibly be the cost to produce a given quantity of output. However, the NGA believes that guidance should be provided in determination and calculation of the average manufacturer's price before it is used as a benchmark.

- Tighten asset transfer rules, increase look back period from 3 to 5 years, and begin ineligibility period at the later of the date of application or nursing home eligibility (\$1.5 billion over five years)
- Allow tiered co-payments for drugs and allow states to enforce co-payments⁶ (\$2 billion over five years)
- Change statute to provide that managed care organizations as a provider class are treated the same as other provider classes (\$1.2 billion)

MONTANA IMPACT

The impact of Medicaid Commission recommendations to Montana has not been determined. Changing the base price for drug reimbursement would likely result in savings if the average manufacturer's price were determined within federal guidelines.

The Montana impact of managed care organization rebate and taxation proposals is unknown. Neither may have any affect since there are no contracts in the Montana Medicaid program for covering all or nearly all Medicaid services for an eligible person for a fixed monthly or capitated fee.

The 2005 Legislature considered legislation (HB 117) to implement the recommendation of the Governor's Health Care Advisory Council (Medicaid redesign) to extend the asset transfer look-back period to 5 years and begin the penalty period due to disallowed asset transfers at the time of Medicaid eligibility. The bill was tabled in committee. There was no fiscal note for the bill and no cost savings estimates were provided in the redesign report.

The tiered co-payment concept is more applicable to the 1115 (demonstration) waiver proposal that the DPHHS is preparing as a result of legislative approval of several Medicaid redesign proposals. Although the executive has been reviewing draft documents outlining the waiver proposal since early August, copies of the document have not been made available for legislative staff.

NATIONAL GOVERNORS' ASSOCIATION

The National Governors' Association (NGA) has also proposed long- and short-term Medicaid program changes with the primary goal of cost stability for states. The short-term changes are those the NGA believes can be included in the 2006 federal budget reconciliation and are more detailed and numerous than either the President's or Medicaid Commission's recommendations. A highly summarized list of the short term recommendations is included as attachment 2.

The NGA proposals can be broadly grouped into four categories and would affect prescription drug coverage, eligibility, benefit administration, and other Medicaid program attributes. The Medicaid Commission suggestions are also included in the NGA recommendations. The remaining NGA recommendations are focused on giving states broader flexibility to tailor benefit packages and co-payments to covered populations, as well as increasing match rates for certain activities and requesting federal cost sharing in management initiatives to make health care administration more efficient, such as those undertaken by the Medicare program.

⁶ States would be allowed to impose higher co-payments for non-preferred drugs on persons with incomes above 100 percent of the federal poverty level.

KATRINA FACTOR/MONTANA IMPACT

Some beltway observers believe that the impact of hurricane Katrina may also extend to federal action on policy changes to the Medicaid program. Congress may postpone consideration of Medicaid program cutbacks that involve service or cost sharing changes until Katrina refugees' lives are more stable. Additionally, there have been media reports that Congress may also delay implementation of the Medicare Part D prescription drug program scheduled to begin January 1, 2006.⁷

However, there are also reports that Congress will include some of the NGA recommendations in legislation to be considered by the House Energy and Commerce Committee.⁸ The committee chairman (Joe Barton R-Texas) said that a number of the NGA proposals are common sense. Those noted specifically by the chairman are:

- Making it more difficult for wealthy seniors to shift or hide assets in order to qualify for nursing home coverage
- Reducing Medicaid overpayments for drugs
- Allowing states to charge basic co-pays to higher income beneficiaries
- The impact to Montana of any changes considered by Congress will of course be dependent on the details of the proposals.

⁷Medicare Part D will impact all state Medicaid programs and is discussed in another update to the Legislative Finance Committee at its October 3 and 4 meeting.

⁸CCH Health Care, "Medicaid Reform Legislation to Contain NGA Reforms", internet article listed at <http://health.cch.com>, September 21, 2005.

ATTACHMENT 1

MONTANA MEDICAID IMPACT UNDER THE ORIGINAL FEDERAL EXECUTIVE BUDGET AS PROPOSED

Case management services are provided in the children and adult mental health, developmental disability, senior, and physically disabled Medicaid programs and the foster care program primarily as a function to support persons in community services. Case management services are also provided to high-risk pregnant women and children with special health care needs. In June, the Department of Public Health and Human Services estimated that it would nearly double the FY 2005 general fund cost to continue current level case management services at the 50 percent match rate (\$6.5 million general fund under current match rates and an additional \$5.1 million general fund with a 50 percent match rate).⁹ This estimate does not include the cost to continue services that might be disallowed for federal Medicaid reimbursement due to the change in case management definition.

Disabled persons living in the community would be the group most affected by proposals to narrow the type of case management and rehabilitation services eligible for federal Medicaid reimbursement. Children in foster care and those with a serious emotional disturbance would also be impacted. Examples of Montana Medicaid rehabilitation services include the Program for Assertive Community Treatment (PACT) for adults with a serious and disabling mental illness, some types of wrap around services that might be funded in the developing children's system of care, and some in-home and community based services provided to developmentally and physically disabled individuals. Rehabilitation services are not defined in statutes governing the Medicaid program and the proposed changes are embodied in five pages of definitions. There are no Montana specific cost estimates for this aspect of the president's proposal.

Lowering the limit for provider taxes from 6 to 3 percent of gross receipts of the class of providers subject to the tax would affect states' ability to use provider tax revenue as Medicaid matching funds. Montana currently levies two bed taxes and uses the proceeds as state match for those Medicaid services – one on nursing homes (\$7.05 per day in FY 2006 and \$8.30 in FY 2007) and one on hospitals (\$29.70 per day for the first 6 months in 2006 and \$27.70 for the last six months in 2006 and the first six months in 2007). If this cap is imposed, it could impact the nursing home bed tax, which is anticipated to generate \$3.5 million of the total \$45 million state match for nursing home services in FY 2006 and has been used to increase rates paid for nursing home services.

⁹Future case management costs would likely be higher if the legislature continued to authorize appropriation increases designed to provide more community services for persons who might otherwise be in a state or other institution (Montana State Hospital, Montana Developmental Center, Montana Nursing Care Center, nursing homes, hospitals) and also provided the same level of case management services to those newly served in community expansions.

Changes in the upper payment limit for Medicaid services might impact providers whose rates are above the actual cost of services. Currently, the upper payment limit is what Medicare pays for the service or would pay using a Medicare reimbursement methodology.

Further limitations on or elimination of intergovernmental transfers (IGTs) would impact nursing home payments.¹⁰ Currently, the appropriation of IGT funds would support an average of \$16.17 per day of the total appropriations for nursing home Medicaid payments made by the legislature (\$126.32 in FY 2006). IGT revenue appropriations are \$16 million of the total \$145 million appropriation for state nursing home match in FY 2006.

There are no Montana specific estimates of the proposed changes to provider taxes, IGTs, or upper payment limits. However, because of the use of all of these funding mechanisms in nursing home reimbursement, that Medicaid service and to a lesser extent hospital services, will feel the brunt of the impacts if the proposals are adopted.

The administrative cap would provide a type of block grant for Medicaid administration that is indexed by the change in the urban consumer price index. There are no specific Montana impact estimates. However, this proposal comes at a time when the administrative costs associated with implementing and administering the Medicare Part D prescription drug plan will be causing state Medicaid administrative costs to rise.

¹⁰Montana has structured its IGT program to comply with federal rules, including the most recent changes that require counties to use IGT revenue for operation of nursing homes.

ATTACHMENT 2

NATIONAL GOVERNORS' ASSOCIATION SUGGESTED SHORT RUN MEDICAID COST SAVINGS MEASURES

Recommendations on Prescription Drugs

- Use of average manufacturer price rather than average wholesale price for Medicaid reimbursement
- Allow states the option to establish a closed formulary
- Give states flexibility to establish dispensing fees and combine different covered populations such as state employees and Medicaid beneficiaries on both an interstate and intrastate basis to establish purchasing pools
- Increase minimum rebates for brand name drugs
- Extend drug rebates to drugs purchased by Medicaid managed care contractors
- Establish an upper payment limit for drugs based on the average manufacturer's price
- Allow states to establish tiered co-payments for higher income Medicaid populations
- Allow states the option of mail order for maintenance drugs

Recommendations on Long Term Care

- Extend look back period for asset transfers to qualify for Medicaid from 3 to 5 years
- Begin penalty periods for illegal asset transfers at the time of Medicaid application
- Prevent shelter of excess resources in trusts and annuities
- Use reverse mortgages, with a portion of home equity sheltered (the lower of 10 percent of market value or \$50,000) and allow states an opt out provision
- Allow all states to enter into long-term care insurance partnerships

Recommendations on Cost Sharing

- Maintain current cost sharing provisions for persons at or below 100 percent of the federal poverty level
- Give states the authority to enforce cost sharing provisions
- Allow states to increase cost sharing or impose premiums for persons with incomes above 100 percent of the federal poverty level, with the cap of 5 percent of total family income up to 100 percent of the federal poverty level and a cap of 7.5 percent for those with higher incomes

Benefit Administration

- Allow greater state flexibility (without waivers) to tailor benefit packages to different health care needs of Medicaid beneficiaries
- Facilitate greater ease in waiver approvals
- Require the U.S. Department of Health and Human Services to “stand by” states when a waiver or Medicaid state plan is questioned in the judicial system
- Partner with the states to make statutory and regulatory changes to the Medicare Part D clawback to ensure that the congressional intent of the program is realized and states are given some form of relief

Other Recommendations

- Implement tax credits and deductions for long term care insurance
- Increased federal match rate or other payment for quality improvements such as chronic health care; adoption of health information technology; improved patient safety
- Implement tax credits and purchasing pools to assist low-income working individuals in purchasing long term care insurance
- Allow higher federal match rate for some fraud and abuse activities
- Allow states to limit, restrict or suspend eligibility of beneficiaries and providers, subject to due process, who have been determined in state proceedings to have engaged in Medicaid fraud and abuse
- Allow states to refund an overpayment attributable to fraud and abuse in the quarter in which the payment was made